NEW YORK STATE COMMISSION OF CORRECTION

In the Matter of the Death of Kevin Schmitt, an inmate of the Ulster County Jail	: : : : :	FINAL REPORT OF THE NEW YORK STATE COMMISSION OF CORRECTION

TO: Sheriff Paul Van Blarcum
Ulster County Sheriff's Office
380 Boulevard
Kingston, NY 12401

GREETINGS:

WHEREAS, the Medical Review Board has reported to the NYS Commission of Correction pursuant to Correction Law, section 47(1)(d), regarding the death of Kevin Schmitt who died on September 4, 2009 while an inmate in the custody of the Ulster County Sheriff at the Ulster County Jail, the Commission has determined that the following final report be issued.

FINDINGS:

1. Kevin Schmitt was a 50 year old white male who died on 9/4/09 at approximately 9:22 a.m. from blunt force trauma as a result of a suicide attempt at the Ulster County Correctional Facility. Schmitt was in custody of the Ulster County Sheriff when he jumped to his death from the upper tier of his housing area. The failure of the Ulster County Sheriff's Office to provide adequate supervision and a comprehensive mental health assessment and psychiatrist referral based on significant risk information reported to the jail was implicated in Schmitt's death. Ulster County Correctional Facility's medical and mental health services are provided pursuant by contract by Correctional Medical Care, Inc. (CMC), a business corporation holding itself out as a medical care provider.

2. [redacted]

3. Schmitt was a self-described "workaholic" who was self employed running a landscaping/snow removal business with his ex-wife.

4. [redacted]

5. [redacted]

6. [redacted]

7. Schmitt had no known significant medical history.

8. In the instant offense, Schmitt confronted his ex-wife and her male acquaintance with two loaded .308 caliber rifles. He allegedly struck the woman with a rifle butt and scuffled with the man inside her house before barricading himself in his own nearby home with three weapons. He surrendered some 10 hours after the start of the incident and was taken into custody.

9. Schmitt was arraigned by Judge M.W. on 9/1/09 who ordered in the Special Orders/Instructions of the securing order, a CPL 730 (competency) exam, a mental health referral and under additional comments, "Suicide Watch!" He was remanded to the Ulster County Correctional Facility in lieu of $50,000/$100,000 cash/bond bail.

10. Upon admission, Schmitt was screened by Officer S.R., scoring a "6" (high risk) on his Suicide Prevention Screening Guidelines including:

Observations of Arresting/Transporting Officer

#1 Arresting or transporting officer believes that detainee may be a suicide risk, if YES, notify supervisor: with a general comment by the screening officer, "Made suicidal statements to police." This question is a shaded area on the screening form designed for

automatic notification to the supervisor and the institution of constant supervision.

Schmitt answered affirmatively to:

#3 Detainee has experienced a significant loss within the last six months (e.g., loss of job, loss of relationship, death of close family member): stating "brother died."

#6 Detainee has history of drug or alcohol abuse: stating, "beer Sunday."

#7 Detainee has history of counseling or mental health evaluation/treatment: reporting Benedictine Hospital Psych.

#10a Detainee has previous suicide attempt: reporting he cut his wrists in 1998.

#11 Detainee is expressing feelings of hopelessness (nothing to look forward to): stating "work." It should be noted that this box was checked "no" in error as Schmitt responded he was concerned about work.

#12 This is detainee's first incarceration in lockup/jail: reporting first time.

In the Officer's Comment section, Officer S.R. documented, "states no thought of suicide at this time."

11. Sgt. A.T., the intake supervisor, was notified and signed the Suicide Prevention Screening Guidelines. Schmitt was assigned constant supervision with a comment, "pending medical screening." The referral section was marked by Officer S.R. for referrals to Medical/Mental Health as non-emergencies.

12. [redacted]

13. [redacted]

14. [redacted]

15. [redacted]

16. The social worker failed to conduct a comprehensive mental health exam and risk assessment on a patient with a high level of risk factors. [redacted] K.B.'s findings contradict the intake screening results, K.B., LCSW-R, improperly released Schmitt from constant supervision. Schmitt was not referred to a psychiatrist for further evaluation prior to his release from constant supervision. The social worker would have had access to the nurse's notes, the nursing referral, the judge's security order and the Suicide Prevention Screening Guidelines. In an interview, K.B. could not recall if she had reviewed this information prior to seeing Mr. Schmitt. The assessment performed by K.B., LCSW-R, was grossly incompetent, flagrantly substandard and missed abundant signs of suicide risk.

17. According to K.B., LCSW-R, there is no CMC policy and procedure in place for conducting mental health and risk assessments. K.B. stated that, although she didn't know the extent of what happened with Schmitt, she did know he was in more trouble than he was admitting to. She reported that she knew he would find out the reality of his situation when he went to court on 9/3/09. Commission staff inquired as to whether she planned on seeing him following his court appearance and she stated that she had planned

to see him but "did not have time that day." This information was not shared with correctional staff.

18. Schmitt was transferred to H-Block, the classification unit, following his release from constant supervision.

19. [redacted]

20. On 9/2/09 at approximately 10:30 p.m., Officer K.D. received a phone call in reception from a female stating she was a family member and expressed concern for Schmitt's mental stability and his past psychiatric history. She asked that he be checked on. She did not wish to identify herself. Cpl. G.S. immediately sent his task officer to Schmitt's housing area and had him escorted to the medical department. He reported this to Cpl. R.T., the oncoming supervisor.

21. [redacted]

22. At approximately 11:46 p.m., Cpl. R.T. was notified by RN M.T. that Schmitt was not a danger to himself or others and he was cleared for general population. RN M.T. was not interviewed as she is no longer employed at the Ulster County Correctional Facility.

23. On 9/3/09, Schmitt made a court appearance, leaving the facility at approximately 1:30 p.m. and returning at approximately 3:30 p.m. His bail was not reduced.

24. On 9/4/09, Officer A.M. started his B-line shift by entering H-pod at approximately 7:55 a.m. He relieved Officer P.R., who had briefed him on the prior shift's issues, none of which included Schmitt. Officer A.M. conducted a supervisory round, called in his count and signed the log book. H-pod is split into two sides, the right side used for classification inmates where Schmitt was housed. The left side of the pod is for inmates on keeplock, i.e., inmates locked in for 23 hours/day. Officers R.F. and P.J. entered the pod to start running showers and recreation for keeplock inmates.

25. During the time that inmates were being run for showers and recreation, Schmitt called Officer A.M. via the intercom and

requested a phone call. Officer A.M. told Schmitt he would have to wait a minute due to the movement on the other side. Officer A.M. also needed to check to see if Schmitt was allowed to have a call at the time requested.

26. A short time later, Officer A.M. informed Schmitt he could have a ten minute phone call and opened Schmitt's cell. Officer A.M. watched Schmitt walk down the stairs, turned the phones on, and then turned away to sit and record his log entries. Officer A.M. was still writing his entries when he heard a loud noise. He stated that no more than two minutes had passed since he saw Schmitt descend the stairs and walk to the phones. He initially thought the noise was the phone slamming and stood up looking towards the phones and not seeing Schmitt at the phones, scanned the pod and saw Schmitt lying on his left side on the floor in front of the shower with a large amount of blood around his head.

27. Officer A.M. called a medical emergency at approximately 8:28 a.m. Cpl. R.C., Officers G.H., M.B., R.F., and P.J. responded. Officers G.H. and M.B. and RN T.A. conducted a quick assessment.

28. [redacted]

29. Officer A.M. reported that he never saw Schmitt go back up the stairs and that the phones are not visible when seated in the officer's booth. No other inmates were out of their cell at the time of the incident and the other officers had left the pod with Inmate Q.

30. A review of facility phone records revealed that Schmitt did not make a phone call that morning.

31. Officer P.R. was assigned to Schmitt's housing area during the night shift prior to Schmitt's suicide. He stated in interview that at approximately 6:00 a.m. Schmitt came to his cell door and asked Officer P.R. when "chow" was coming. He recalled Schmitt ate all

of his food and asked for a second beverage. He reported that Schmitt had slept all night and acted very normal.

32. Immediately following Schmitt's suicide, CMC reviewed their Suicide Prevention Policy whereby, "Regardless of who places the inmate on constant supervision, only a psychiatrist may release the inmate back to general population."

33. Following the incident, Inmate D.T. gave Detective D.L. a statement regarding a conversation he had with Schmitt on 9/3/09 during recreation. He reported that Schmitt told him he had nothing to live for and stated that he would not be here tomorrow, that he was going to jump off the railing. Inmate D.T. stated that he told Schmitt that he didn't believe him. "He said he was going to kill himself." Inmate D.T. stated that he never told anyone because he didn't believe Schmitt.

Inmate D.T. reported that he saw the officer let Schmitt out and Schmitt walked downstairs towards the phone, then came back up the stairs and walked over to the railing and "after that all you heard was a thump."

34. Video was forwarded to the Commission which clearly reveals Schmitt diving head first off the upper floor.

RECOMMENDATIONS:

TO THE ULSTER COUNTY SHERIFF:

1. The Ulster County Sheriff shall direct that a review be conducted by the mental health contract provider, Correctional Medical Care, Inc., of the mental health services afforded Schmitt during his incarceration. Specific attention should be focused on the failure of the social worker to conduct a comprehensive mental health exam and risk assessment on a patient with a high level of risk factors and failure to refer Schmitt to the psychiatrist. Also, the discontinuance of constant supervision without a psychiatric evaluation, remarkably as the judge had ordered a 730 exam and noted "suicidal" on the securing order. The results of this review shall be reduced to writing and forwarded to the Medical Review Board upon completion. Any delay or denial by CMC, Inc. respecting this recommendation should result in termination of their contract for cause.

2. The Ulster County Sheriff shall develop policy/procedure in cooperation with classification, and medical and mental health services at the Ulster County Correctional Facility whereby all inmates are re-screened/classified following significant changes in the inmate's status and/or notification from family or friends regarding concerns of an inmate's risk for suicide. Other events to be considered for re-screening include conviction of

serious/heinous charges, elevation of charges, heavy sentencing, or other stressful events.

3. The Sheriff shall post signs in jail lobby, the visiting room, inmate housing area, the booking area, interview rooms and any other area of your facility where inmates or visitors are permitted informing them of the need to report knowledge of inmates threatening self harm. This information should also be included in inmate handbooks.

TO THE NYS EDUCATION DEPARTMENT, OFFICE OF THE PROFESSIONS:

That the Office of the Professions undertake an inquiry into the status of Correctional Medical Care, Inc., a Pennsylvania corporation, as a lawful medical practitioner in New York State.

WITNESS, HONORABLE PHYLLIS HARRISON-ROSS, M.D., Commissioner, NYS Commission of Correction, 80 Wolf Road, 4th Floor, in the City of Albany, New York 12205 this 18th day of March 3, 2011.

Phyllis Harrison-Ross, M.D.
Commissioner

PHR:mj
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